MONTANA STATE BOARD OF NURSING
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OFFICE USE
PROG# _____
APPROVED:
YES ___ NO ___
DATE: _____

ASSISTED LIVING MEDICATION AIDE PROGRAM APPROVAL APPLICATION

Attach a <u>complete</u> program outline or syllabus along with a schedule of clinical hours and the name of the facility where the clinical hours will be met.

NAME of FACILITY: _____

ADDRESS: _____
(STREET, PO BOX) (CITY) (STATE) (ZIP)

CONTACT PERSON: _____ Telephone: _____

PROGRAM TITLE: _____

PROGRAM INSTRUCTOR(S)(must be approved by the Board of Nursing):

_____

I hereby certify the above titled program includes the following, which meets or exceeds the provisions of ARM 8.32.427.

Total hours of instruction time

Total hours of didactic classroom presentation: _____
32 hrs minimum

Total hours of simulated practical experience: _____
8 hrs minimum

Total hours of direct, supervised, clinical experience: _____
40 hrs minimum

Instructor to student ratio

Classroom setting: _____ to _____
Minimum ratio = 1:10

Clinical setting: _____ to _____
Minimum ratio = 1:5

The following mandatory Components are included:

_____ The six rights of medication administration
_____ Purposes of medications
_____ Classes of medications
_____ Allowable routes of administration of medications
_____ Care, storage and regulation of controlled substances and medications
_____ How to administer medications
_____ Adverse reactions, side effects and allergies to medications
_____ Medication log
_____ Medication error reporting
_____ Documentation
_____ How and when to report to the supervising nurse
_____ Completion of the Board approved skills checklist

Signature: _____ Date: _____